



University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient's name: _____
Last Name Given name Middle Initial

MRN

Date of Birth

Address: _____
Street City Province Telephone #: _____

The undersigned hereby authorizes/requests the _____
Health Care or Health Services Provider

To provide: _____
Name of Third Party

Address: _____
Street City Province Postal Code

With access to/or photocopies from (circle which) my medical records. The reason for this request is: _____

The records I authorize to be accessed or photocopied are as follows:

- ☐ All records
☐ For review only
☐ Only records relating to the following treatment or admission:

Type of Treatment: _____ Dates of Treatment: _____

Expiration Date: (6 months or as stated) _____

Signature of Patient Signature of Witness Date

IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO.

Signature of Legal Representative Relationship Name of Witness (Please Print) Date

1. This authorization may be rescinded or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
2. This authorization must contain the original signature of:
 - a) The patient, or the parent or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent, and
 - b) The witness to the patient's signature.
3. Requests for release of information must be dated after treatment dates.
4. If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

Signature of Interpreter Name of Interpreter/Relationship to Patient if Any (Please Print) Date

